II

111TH CONGRESS
1ST SESSION

S. 1307

To amend part C of title XVIII of the Social Security Act with respect to Medicare special needs plans and the alignment of Medicare and Medicaid for dually eligible individuals, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 19, 2009

Mr. FEINGOLD (for himself and Ms. KLOBUCHAR) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend part C of title XVIII of the Social Security Act with respect to Medicare special needs plans and the alignment of Medicare and Medicaid for dually eligible individuals, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Specialty Care Improvement and Protection Act of 2009''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. EXTENSION OF SNP AUTHORITY.

Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended—

(1) by striking ''2011'' and inserting ''2014''; and

(2) by adding at the end the following new sentence: ''In the case of a specialized MA plan for special needs individuals that is designated as a Fully Integrated Dual Eligible Special Needs Plan under section 5(a)(1) of the Medicare Specialty Care Improvement and Protection Act of 2009, the preceding sentence shall be applied by substituting '2016' for '2014'.''.

SEC. 3. IMPROVE RISK ADJUSTMENT FOR HIGH-RISK, HIGH-COST BENEFICIARIES.

(a) EVALUATION.—

(1) IN GENERAL.—The Secretary shall evaluate the Medicare Advantage risk adjustment payment

mechanism under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) and the risk adjustment payment mechanism under section 1860D–15(c)(1)(A) of such Act (42 U.S.C. 1395w–115(c)(1)(A)) in order to resolve plan payment inequities relative to Medicare fee-for-service payments for beneficiaries identified under paragraph (2).

(2) REQUIREMENTS.—The evaluation conducted under paragraph (1) shall address the need for improving the adequacy of the existing hierarchical condition categories and pharmacy risk adjustment methods for Medicare Advantage plans that exclusively or disproportionately serve high-risk beneficiaries as it relates to—

(A) accurately predicting costs relative to Medicare fee-for-service for beneficiaries with—

(i) sustained high-risk scores over multiple contract periods;

(ii) sustained high costs over multiple contract periods;

(iii) co-morbid chronic conditions;

(iv) diagnoses not included in the risk-adjustment methodology, including dementia and other cognitive impairments;

(v) physical disabilities, developmental disabilities, or both; and

(vi) frailty;

(B) accurately predicting costs relative to Medicare fee-for-service for beneficiaries near the end of life;

(C) accurately predicting costs relative to Medicare fee-for-service for other conditions for which the current risk adjustment methodology underpays in relation to Medicare fee-for-service, as determined by the Secretary;

(D) further gradations of diseases and conditions to better reflect stage of condition, condition severity, and costs related to burden of illness;

(E) accounting for costs of pre-existing conditions at the time of initial enrollment for new entrants into Medicare; and

(F) enhancing coding persistency by calculating risk scores using data covering at least 2 years.

(b) USE OF THE RESULTS OF THE STUDY FOR REFINEMENTS.—

(1) REFINEMENTS.—

(A) IN GENERAL.—Beginning with plan year 2011, the Secretary, using the results of the evaluation conducted under subsection (a)(1), shall refine the risk adjustment payment mechanisms referred to in subsection (a)(1) for beneficiaries identified under subsection (a)(2). The Secretary shall make additional refinements, as appropriate, for subsequent plan years.

(B) PROTECTION.—To the extent that the Secretary determines that the risk adjustment payment mechanisms referred to in subsection (a)(1) do not accurately pay for Medicare beneficiaries identified under subsection (a)(2), the Secretary shall ensure that a Medicare Advantage plan that exclusively or disproportionately serves high-risk beneficiaries is not paid less, in the aggregate, than 100 percent of Medicare fee-for-service payment rates (as determined under section 1853(c)(1)(D)(i)).

(C) RECALIBRATION.—Beginning with plan year 2011, the Secretary shall recalibrate the risk adjustment payment mechanisms referred to in subsection (a)(1) so that the overall predicted costs for all Medicare beneficiaries are

identical to what they would have been in the absence of the new risk adjustment payment mechanism.

(2) BUDGET NEUTRAL ADJUSTMENTS.—If the Secretary determines that the application of paragraph (1) results in expenditures under title XVIII of the Social Security Act that exceed the expenditures under such title that would have been made without such application, the Secretary shall provide for an appropriate adjustment to payment rates under part C of such title for beneficiaries for whom the risk adjustment payment mechanism overpays in relation to Medicare fee-for-service in order to eliminate such excess.

SEC. 4. ADDITIONAL ENHANCEMENTS TO ENSURE PAYMENT EQUITY FOR SPECIALIZED MA PLANS.

(a) ACCOUNTING FOR ADDED REGULATORY COSTS.—For plan year 2011 and subsequent plan years, the Secretary shall provide bonus payments to account for added SNP costs associated with additional benefit, care management, reporting, and other requirements established by Congress and the Secretary in excess of other Medicare Advantage plans.

(b) ENSURING FAIR BIDDING PRACTICES.—For plan year 2011 and subsequent plan years, the Secretary shall

take into account the following factors with respect to the bid structure for SNPs:

(1) Dual eligibility.

(2) Geographic cost differences.

(3) Population characteristics.

(4) The differences in plan requirements, including differences in additional benefits, care management, and reporting requirements.

(5) The differences between community-based and regional or nationally based plans.

(c) AUTHORITY TO APPLY PACE RULES.—For plan year 2011 and subsequent plan years, the Secretary may apply the payment rules under section 1894(d) of the Social Security Act (42 U.S.C. 1395eee(d)) to Fully Integrated Dual Eligible Special Needs Plans rather than the payment rules that would otherwise apply to such plans under part C.

(d) BUDGET NEUTRAL ADJUSTMENTS.—If the Secretary determines that the application of subsections (a), (b), and (c) result in expenditures under title XVIII of the Social Security Act that exceed the expenditures under such title that would have been made without such application, the Secretary shall provide for an appropriate adjustment to payment rates under part C of such title for beneficiaries for whom the risk adjustment payment mech-

anism overpays in relation to Medicare fee-for-service in order to eliminate such excess.

SEC. 5. ADVANCE ALIGNMENT OF MEDICARE AND MEDICAID FOR DUAL ELIGIBLES.

(a) MEDICARE AND MEDICAID INTEGRATION PROGRAMS.—

(1) DESIGNATION.—

(A) IN GENERAL.—For plan year 2011 and subsequent plan years, the Secretary shall have in place a process under which the Secretary designates dual eligible SNPs as Fully Integrated Dual Eligible Special Needs Plans for the purpose of advancing fully integrated Medicare and Medicaid benefits and services for dual beneficiaries, including State designated Dual subsets.

(B) CRITERIA FOR DESIGNATION.—In order to be designated as a Fully Integrated Dual Eligible Special Needs Plan, the dual eligible SNP shall meet the following requirements:

(i) The dual eligible SNP provides dual eligibles with access to Medicare and Medicaid benefits specified by the State for Medicaid beneficiaries enrolled in inte-

grated programs under a single managed care organization (MCO).

(ii) The dual eligible SNP has a contract in place with a State Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing.

(iii) The dual eligible SNP coordinates the delivery of covered Medicare and Medicaid health and long-term care services, consistent with State policy, using aligned care management and specialty care network methods for high-risk beneficiaries.

(iv) The dual eligible SNP employs policies and procedures approved by the Secretary and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality assurance.

(v) The dual eligible SNP provides advanced person-centered, integrated care for the full array of primary, acute, and residential and home and community-based

long-term care services, using a robust advanced medical home model that—

(I) empowers dual eligibles with serious chronic conditions and their family caregivers to optimize their health and well-being;

(II) provides a comprehensive array of patient-centered benefits and services designed to meet the unique needs of dual eligibles;

(III) helps dual eligibles and their family caregivers to access the right care, at the right time, in the right place, given the nature of their condition;

(IV) aligns the incentives of related care providers to improve transitions and care continuity; and

(V) optimizes total quality and cost performance across time, place, and profession.

(2) INTEGRATION AUTHORITY.—In order to increase simplicity for dual eligibles in accessing and coordinating Medicare and Medicaid benefits, the Secretary, working in conjunction with States, on a

State by State basis, consistent with existing statutory authority, is encouraged to establish a single administrative structure and process under titles XVIII and XIX for Fully Integrated Dual Eligible Special Needs Plans, under a three-way contract or Memorandum of Understanding, among CMS, the State, and related plans, for—

(A) the enrollment of dual eligibles;

(B) member materials and related communications;

(C) care management and model of care requirements;

(D) reporting, auditing, and performance evaluation;

(E) grievance and appeals procedures; and

(F) payment methods.

(3) ALIGNMENT OF MEDICARE AND MEDICAID POLICIES AND PROCEDURES FOR SNPS SERVING DUAL ELIGIBLES.—In order to increase simplicity for dual eligibles in accessing and coordinating Medicare and Medicaid benefits by enhancing coordination between CMS and State Medicaid agencies in the oversight of SNPs insofar as they serve dual eligibles, the Secretary, working in collaboration with State Medicaid agencies, may modify rules, policies,

and procedures under titles XVIII and XIX of such Act in order to provide for the alignment of Medicare and Medicaid requirements, including marketing, enrollment, care coordination, auditing, reporting, quality assurance, and other relevant oversight functions.

(4) REPORTS TO CONGRESS.—

(A) INTERIM REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress an interim report on the impact of integrating Medicare and Medicaid benefits and services on total quality and cost performance in serving dual eligibles.

(B) FINAL REPORT.—Not later than December 31, 2015, the Secretary shall submit to Congress a final report on the impact of integrating Medicare and Medicaid benefits and services on total quality and cost performance in serving dual eligibles.

(C) REQUIREMENT.—A report under subparagraph (A) and (B) shall include recommendations for such legislative and administrative actions as the Secretary determines appropriate to further advance Medicare and Medicaid integration, including options for inte-

grating Medicare and Medicaid funding, to facilitate ongoing improvements in total quality and cost performance in care of dual eligibles.

(D) QUALITY AND COST PERFORMANCE.—Not later than 6 months after the date of the enactment of this Act, the Secretary, working in consultation with consumers, plans, and States, shall identify the measures and benchmarks to be used for evaluating cost and quality performance for purposes of subparagraph (C).

(b) OFFICE OF MEDICARE/MEDICAID INTEGRATION.—

(1) ESTABLISHMENT.—The Secretary shall establish or designate an Office on Medicare/Medicaid Integration (in this subsection referred to as the ''Office'') for the purpose of aligning Medicare and Medicaid policies and procedures and developing tools to support State integration efforts in order to—

(A) simplify dual eligible access to Medicare and Medicaid benefits and services;

(B) improve care continuity and ensure safe and effective care transitions;

(C) eliminate cost shifting between Medicare and Medicaid and among related care providers;

(D) eliminate regulatory conflicts between Medicare and Medicaid rules; and

(E) improve total cost and quality performance.

(2) RESPONSIBILITIES.—The responsibilities of the Office are to develop policies and procedures to—

(A) oversee the designation, implementation, and oversight of Fully Integrated Dual Eligible Special Needs Plans under subsection (a)(1) in collaboration with the States, with authority to effectively align Medicare and Medicaid policy for dual eligibles;

(B) provide State Medicaid agencies with training, materials, technical assistance, and other resources in support of advancing Medicare and Medicaid integration in States where Fully Integrated Dual Eligible Special Needs Plans have been designated and other integration initiatives are being advanced to coordinate and align primary, acute, and long-term care

benefits for dual eligibles through a State plan option or other means;

(C) identify incentives for States to advance the integration of Medicare and Medicaid to improve total cost and quality performance, including shared cost savings among consumers, plans, and Federal and State governments with respect to State initiatives for advancing Medicare and Medicaid integration;

(D) support State efforts to coordinate and align acute and long-term care benefits for dual eligibles through a State plan option or other means;

(E) provide support for coordination of State and Federal contracting and oversight for dual integration programs supportive of the goals described in paragraph (1);

(F) align Federal rules for Medicaid managed care and Medicare Advantage Plans to include methods for integrating marketing, enrollment, grievances and appeals, auditing, reporting, quality assurance, and other relevant oversight functions;

(G) serve as a liaison between CMS central and regional offices to ensure consistent appli-

cation of CMS rules, policies, and auditing practices as such rules, policies, and auditing practices pertain to dual eligibles;

(H) monitor total combined Medicare and Medicaid costs in serving dual eligibles and make recommendations for optimizing total quality and cost performance across both programs; and

(I) work with the Congressional Budget Office and the Office of Management and Budget to establish a process for evaluating total Medicare and Medicaid spending for dual eligibles who are enrolled in Fully Integrated Dual Eligible Special Needs Plans such that the enrollment of such dual eligibles in such plans is treated as ''budget neutral'' if the combined Medicare and Medicaid costs under such plans do not exceed the combined costs of providing Medicare and Medicaid services on a fee-for-service basis for a comparable risk group.

(3) FUNDING FROM SAVINGS.—

(A) IN GENERAL.—For purposes of funding for the Office, there shall be made available for each of fiscal years 2010 through 2014,

$2,000,000 from the savings described in subparagraph (B).

(B) SAVINGS.—The savings described in this subparagraph are the average per capita savings described in paragraphs (3)(C) and (4)(C) of section 1854(b) for which monthly rebates are provided under section 1854(b)(1)(C) in the fiscal year involved.

(C) AVAILABILITY.—Funds made available under this paragraph shall be transferred to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) in the proportion specified in section 1853(f) of such Act (42 U.S.C. 1395w–23(f)).

SEC. 6. MEDICAID PRESUMPTIVE ELIGIBILITY OPTION.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(14) At the option of the State, the plan may provide for a period of presumptive eligibility for an individual who has attained age 65, who has 12 or more consecutive months of eligibility under this title, and who the State

has reason to believe will be determined to be a full-benefit dual eligible individual (as defined in section 1935(c)(6)), but only if the State—

''(A) agrees to randomly conducted eligibility audits by the Secretary; and

''(B) ensures that any individual enrolled under the State plan who is determined to be ineligible for medical assistance as a result of such an audit (and, if such individual is enrolled in a specialized MA plan for special needs individuals under part C of title XVIII, ensures that the organization offering such plan) is notified at least 30 days prior to the date on which the individual is disenrolled from the State plan.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on January 1, 2010.

SEC. 7. EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) in clause (xi), by striking ''and'' at the end;

(2) in clause (xii), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(xiii) such contract provides that (I) payment for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to, and (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.''.

(b) CONFORMING AMENDMENTS.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (d)—

(A) in paragraph (1), by adding at the end the following:

''(C) Notwithstanding the subparagraphs (A) and (B)—

''(i) a Medicaid managed care organization with a contract under section 1903(m) may exclude or otherwise restrict coverage of a covered outpatient drug on the basis of policies or practices of the or-

ganization, such as those affecting utilization management, formulary adherence, and cost sharing or dispute resolution, in lieu of any State policies or practices relating to the exclusion or restriction of coverage of such drugs, provided, however, that any such exclusions and restrictions of coverage shall be subject to any contractual requirements and oversight by the State as contained in the Medicaid managed care organization's contract with the State, and the State shall maintain approval authority over the formulary used by the Medicaid managed care organization; and

''(ii) nothing in this section or paragraph (2)(A)(xiii) of section 1903(m) shall be construed as requiring a Medicaid managed care organization with a contract under such section to maintain the same such policies and practices as those established by the State for purposes of individuals who receive medical assistance for covered outpatient drugs on a fee-for-service basis.''; and

(B) in paragraph (4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by Medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(2) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatients drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(c) REPORTS.—Each State with a contract with a Medicaid managed care organization under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) shall report to the Secretary on a quarterly basis the total amount of rebates in dollars and volume received from manufacturers (as defined in section 1927(k)(5) of such Act (42 U.S.C. 1396r–8(k)(5)) for drugs provided to individuals enrolled with such an organization as a result of the amendments made by this section for both brand-name and generic drugs. The Secretary shall review the reports submitted by States under this subsection and, after such review, make publically available the aggregate data contained in such reports.

(d) EFFECTIVE DATE.—This section and the amendments made by this section take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SEC. 8. DEFINITIONS.

In this Act:

(1) CMS.—The term ''CMS'' means the Centers for Medicare & Medicaid Services.

(2) DUAL ELIGIBLE.—The term ''dual eligible'' means an MA eligible individual (as defined in section 1851(a)(3) of the Social Security Act, 42

U.S.C. 13195w–21(a)(3)) who is also entitled to medical assistance under a State plan under title XIX of the Social Security Act.

(3) DUAL ELIGIBLE SNP.—The term ''dual eligible SNP'' means a SNP described in section 1859(b)(6)(A)(ii) of the Social Security Act.

(4) MEDICAID.—The term ''Medicaid'' means the program under title XIX of the Social Security Act.

(5) MEDICARE.—The term ''Medicare'' means the program under title XVIII of the Social Security Act.

(6) MEDICARE FEE-FOR-SERVICE.—The term ''Medicare fee-for-service'' means the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act.

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(8) SNP.—The term ''SNP'' means a specialized MA plan for special needs individuals, as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)).

(9) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

○